CNA Skills Workshop

Resident & Van Safety

Resident Abuse, Neglect & Theft

Do You Really Know What It Is?

When you enter the nursing home environment

- Your World Changes!
- The Law Changes! (Adult Abuse Act)
- And…It's Personal!

Abuse & Neglect

- Examples of a *Finding* or *Crime* in the facility:
  - If you don’t let me clean you up, you won’t get breakfast. (Abuse)
  - Hurry up and eat or I will send your tray back. (Abuse)
  - If you punch that call button again, I am going to take it away from you. (Abuse)
  - If you don’t get off the pot, I am going to let you sit there all day. (Abuse)

Abuse & Neglect

- Examples of a *Finding* or *Crime* in the facility:
  - If you go into Mrs. XX's room again, I am going to have to whip your butt. (Abuse)
  - Now don't get off of the edge of the bed until I get back with some help. (Neglect)
  - It may not be the diet you are supposed to get, but it's food, so eat it anyway. (Neglect)
  - Mrs. XX, I am supposed to have two people to lift you but I don't have time for that. You will just have to help more. (Neglect)

Theft

- Examples of a *Finding* or *Crime* in the facility:
  - Mr. XX, I am going to take a couple of your cigarettes, and I will pay them back tomorrow. (Theft)
  - Mrs. XX, you have a whole 6-pack of sodas and I need one really bad. I am going to borrow one, and I will pay you back later. (Theft)
  - Mr. XX, I took your radio over the weekend and brought it back today. I knew you wouldn’t mind. (Theft)

The Examples You Just Read…

- …Are just a few of the many ways you can get yourself in trouble if you don't understand what Abuse, Neglect and Misappropriation (theft) of property is.
- Every one of these examples, if proven, can be a *Finding, Placing You on the Registry* or may be a *Crime* that you can be charged with.

The Examples You Just Read…

- In a split-second (lapse of judgment) (not thinking) (verbally reacting) you can lose your occupation and be placed on the registry, turning your world upside down.

Put Yourself on Guard!

- Don’t React To…
  - Sexual slurs or requests by a resident
  - Racial slurs by a resident
  - Pinching or grabbing your breasts or genitals by a resident
  - Pinching, grabbing or hitting you anywhere by a resident
  - Spitting on you, throwing food at you, running over your foot with a wheelchair, or any other action like this by a resident

If You Retaliate Physically or Verbally…

- …It's Abuse!
  - If you hit, slap, pat, spat, tap, or whatever you call it, out of Reflex, it's still ABUSE.
  - If proven, it's a FINDING PLACING YOU ON THE REGISTRY and you could be charged with a CRIME!

When a Resident Has Pushed Your Last Button

- BACK OFF!
- Get your supervisor!
- Let your supervisor know that you need to be reassigned or need some quiet time.

WHAT, WHEN & WHO

DO YOU REPORT ABUSE TO?

WHAT
Do you report?

- Any **Allegation**…
- **Witnessed** Event…
- **Suspicion or Rumor** of…
- Verbal Abuse, Physical Abuse, Sexual Abuse, Neglect and Theft!

WHEN
Do you report?

- Report any allegation, witnessed event, suspicion or rumor of any form of abuse, neglect or theft **IMMEDIATELY!!**

WHO
Do you report to?

- Report **IMMEDIATELY** to the
- **ADMINISTRATOR**

or

- The Administrator's **DESIGNATED REPRESENTATIVE** for your shift!

WHO
Do you report to?

- The **Administrator's Designated Representative** is determined by your nursing home's policies and procedures.
- Make sure you know who the **Designated Representative for the Administrator** is for your shift.

ASK YOUR SUPERVISOR

If you have any questions about the information in this presentation or your facility's policies and procedures, make sure you ask your supervisor. **That is your responsibility!**

Taking Pictures of Residents

A resident **CANNOT** be photographed or videoed without the written consent (permission) of the resident or the resident's legal representative on file in the facility.

Taking Pictures of Residents

Taking Resident Picture, Video and/or Posting to Social Media = **Possible Finding Placing Employee on Registry!**

It's against the law! Make sure you understand your facility's policies and procedures about photos and videos.


BANNED!

Questions?

Everyone's "FALLing" for it!

TEAM Fall

Prevention and Response

OBJECTIVES

Analyze the internal, external and systemic conditions and operations that may be the causes of resident falls

Utilize root cause analysis in the investigation and prevention of resident falls

Should I Be Concerned?

Falls are the **number one** cause of facility-incurred injuries facing nursing homes today.

Injuries caused from falls increase the care required

Strain on facility and family relationships

Quick Facts

- Falls are the greatest medical malpractice exposure
- 40% of all nursing home residents fall each year, many more than once
- 70% of residents die from complications within a year of breaking a hip
- **Greatest risk of falling is during first week of admission**

What CMS says:

Intercepted fall is **still a fall.**

Fall without injury is **still a fall.**

Distance to next lower surface is not a factor.

What now?

CREATE A SENSE OF URGENCY

INVOLVE ALL OF THE STAFF

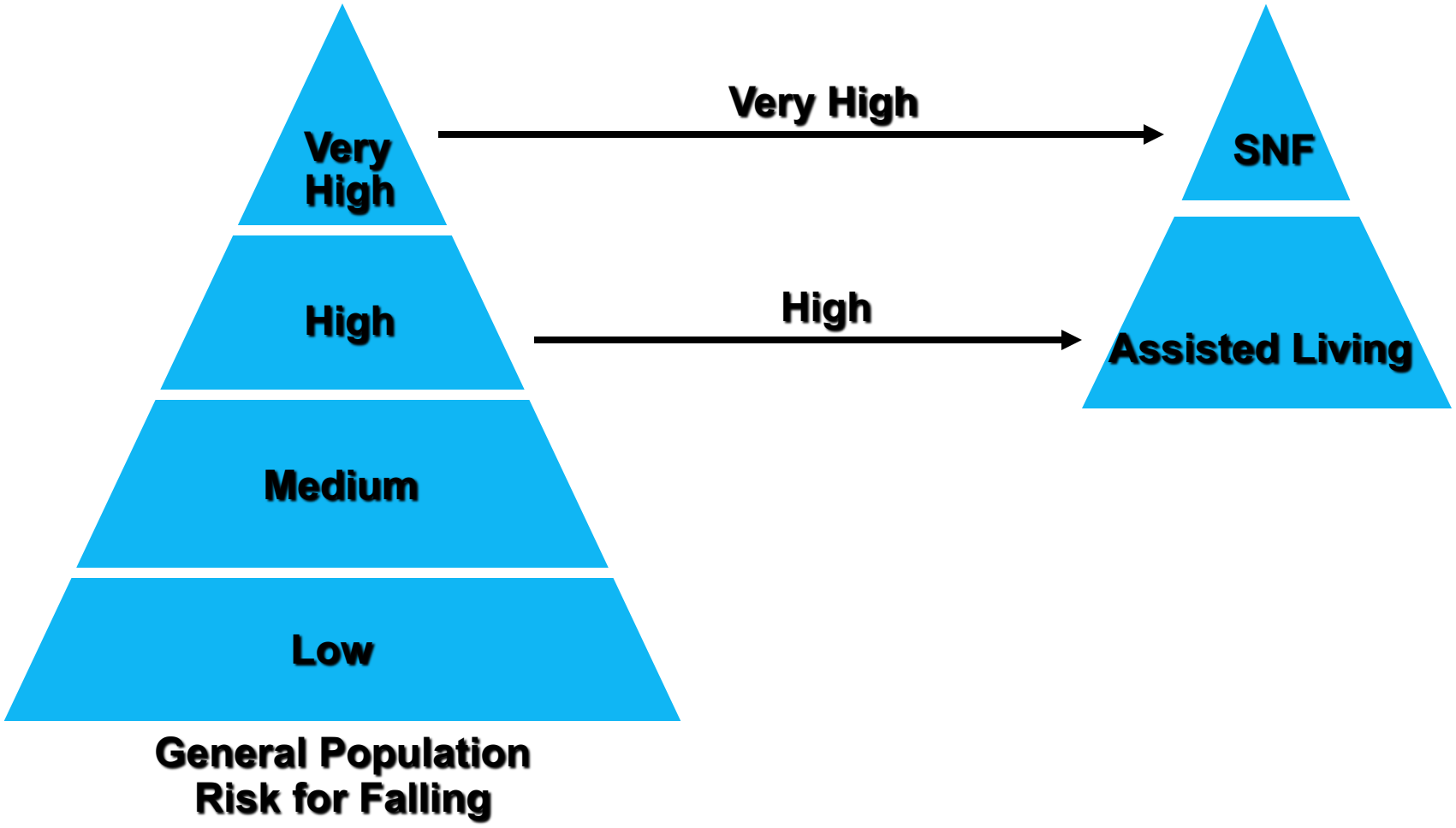
IDENTIFY A FALL MANAGEMENT TEAM

ASSIGN A PROCESS OWNER (PROJECT CHAMPION)

“I did then what I knew then,
when I knew better,
I did better.”

- Maya Angelou

Who is at Risk for Falling . . .
When Everyone Is?



Two Tiered Approach

- **Reactive (post falls action)**
  - **Investigate current falls that occur**
  - **Collect factual evidence from the fall event**
  - **Study the causation of falls**
- **Proactive (fall prevention)**
  - **Speculate on specific risk factors for falls**
  - **Actions based on assessment of conditions specific to individual resident**
  - **Actions based on predictions**

Person Centered "at risk" for falls on admission

- Mr. SP, 74 y.o., lives alone, recently widowed, alcohol dependent, slightly confused, easily agitated, has multiple hematomas from many falls
- Mrs. MW, 69 y.o., 295 lbs., newly diagnosed brittle diabetic, admitted post hip pinning following a fall in her apartment
- Mrs. AT, 76 y.o., active, alert, visually impaired due to macular degeneration, slipped and fell on ice getting out of her son's car, fx elbow & shoulder
- Mr. BL, 88 y.o., early stage Lewy Body Dementia, symptoms increasing, can no longer be cared for in her AL setting

Falls Admission Assessment

Identify	Identify the individual's specific risk factors for falling
Determine	Determine predisposing and precipitating factors if the person has a history of falls
Consider	Consider psychological factors; grief, depression, fear of falling, self imposed restriction of activity
Focus on	Focus on lower-extremity balance and strengthening status

What is root cause analysis?

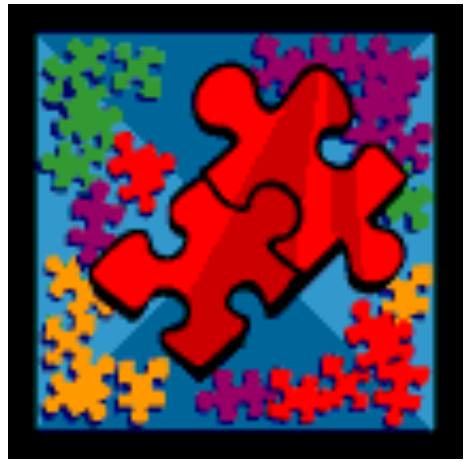
RCA is a process to find out what happened, why it happened, and to determine what can be done to prevent it from happening again.

Root Cause Analysis

- Root cause analysis (RCA) transforms an old culture that reacts to problems, into a new culture that solves problems before they escalate.
- Aiming performance improvement operations at root causes is more effective than merely treating the symptoms of problems.
- Problems are best solved by eliminating and correcting the root causes, as opposed to merely addressing the obvious symptoms with "scatter-gun approaches" to solutions.

The Application of Root Cause Analysis to:

- **Incontinence**
- **Pain**
- **Falls**



What might be the root cause(s) of her incontinence?

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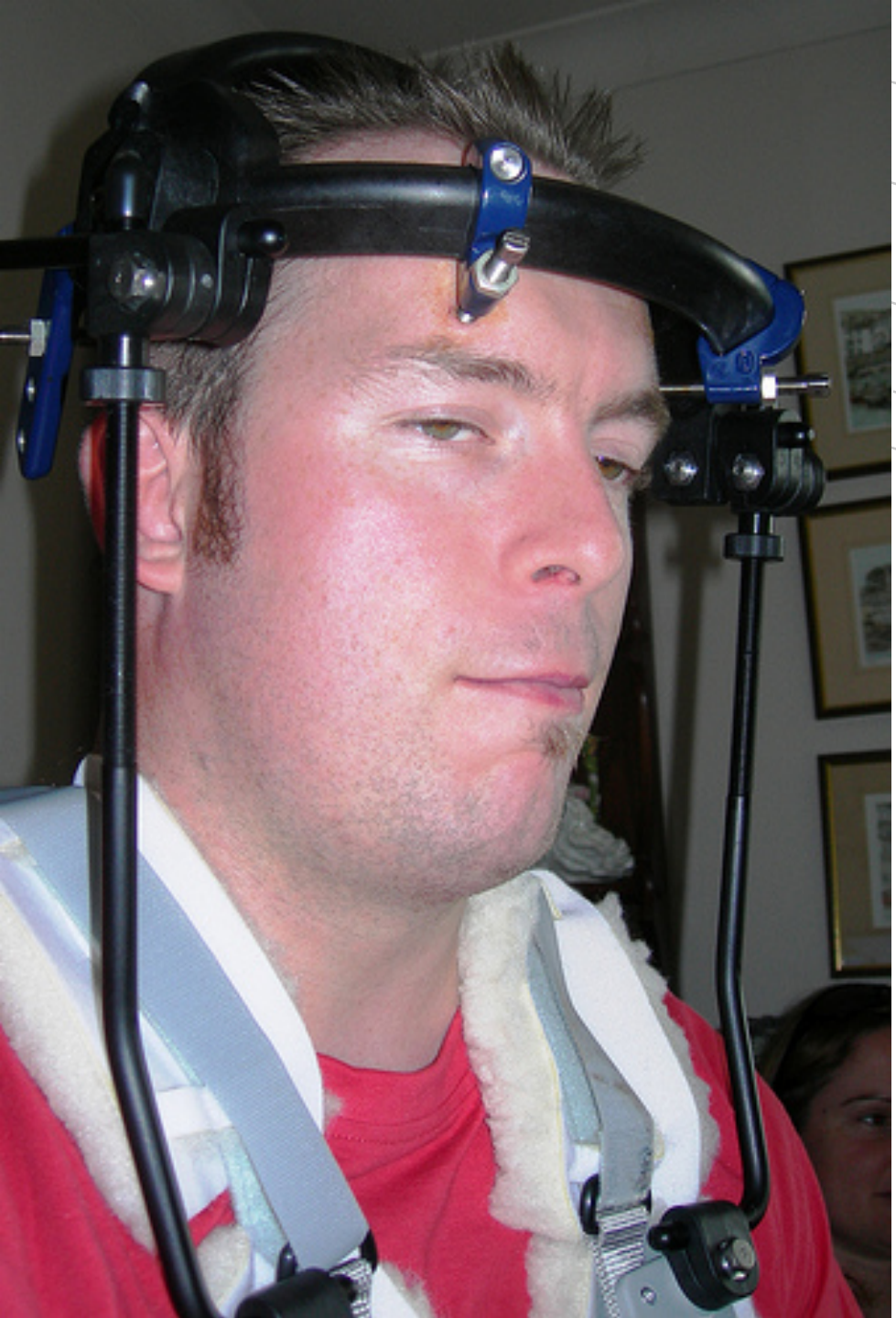
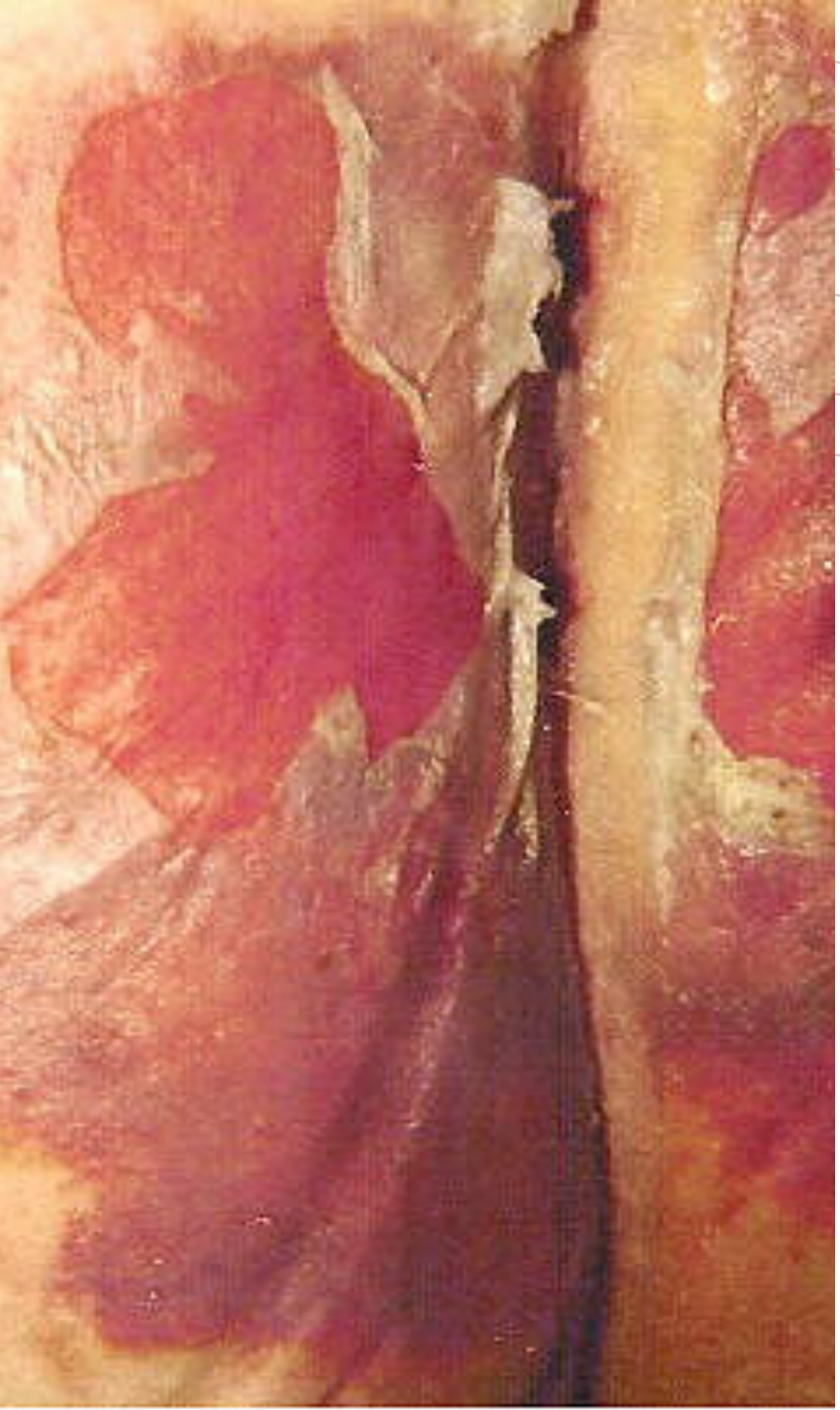
Would you use the same interventions for their incontinence?



What might be the root cause(s) of his pain?



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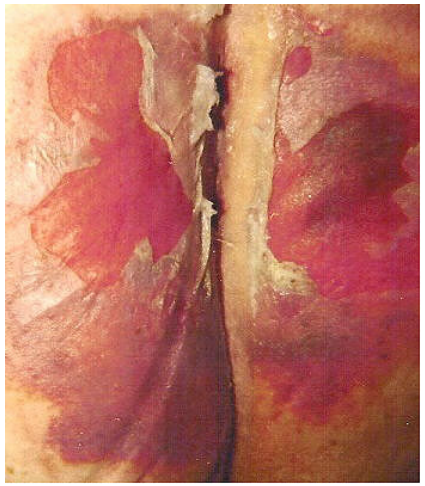

Would you use the same interventions for their pain?

What might be the root cause(s) of his fall?

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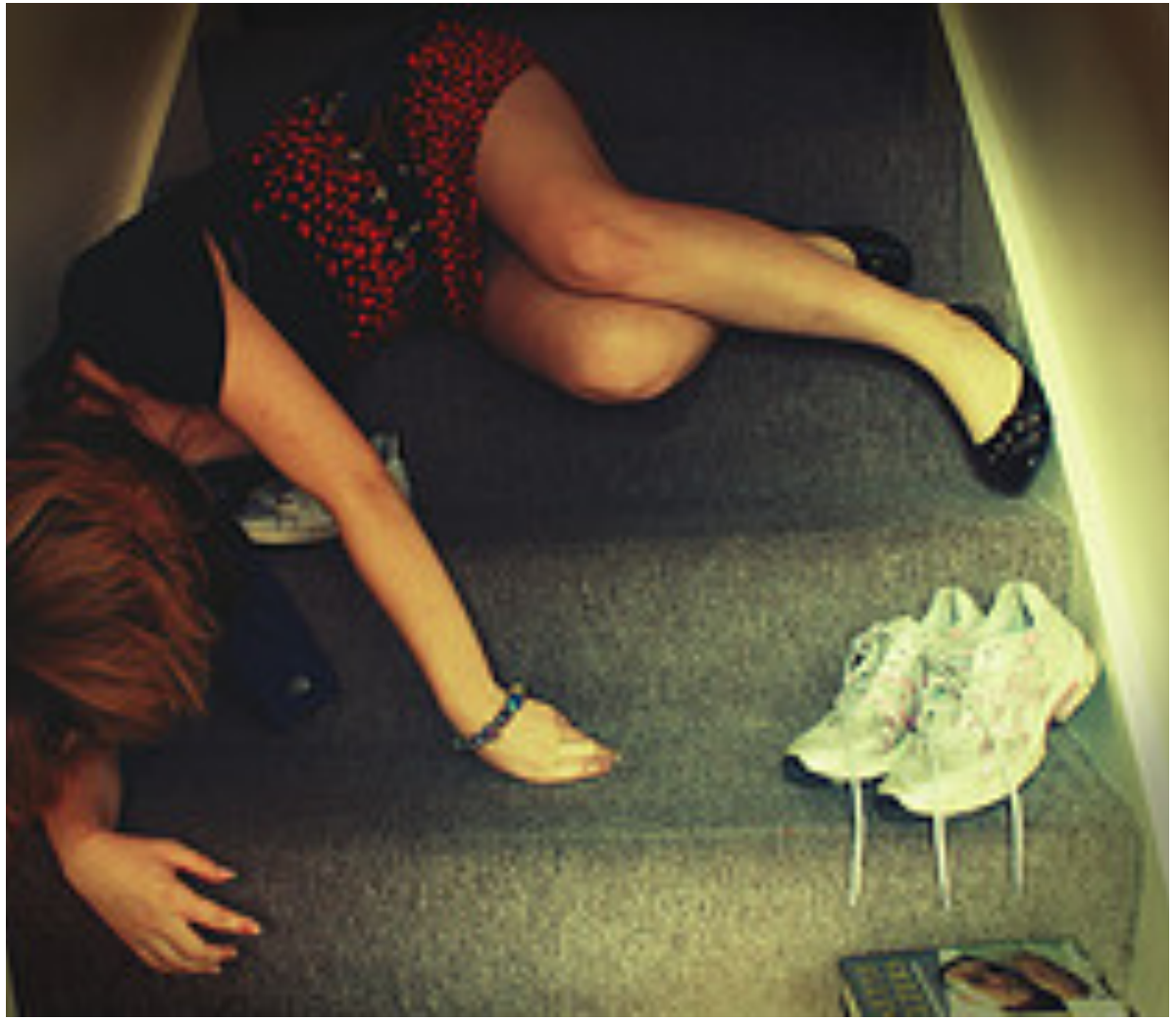


What might be the root cause(s) of her fall?

Would you use the same interventions for their falls?

Why Do RCA After a Fall?

- **Q:** “It’s a single event and won’t happen that way again?”
- **Q:** “No one, including that resident, will ever fall that way again?”
- **A:** If the brakes failed in your car on an icy road, don’t figure out “why” or tell the manufacturer because that accident will never happen that way to you or anyone else again. WRONG!! NOT!

Situations that can hinder, divert, or prevent, successful root cause analysis:

1. **Blame Game**
2. **Tunnel Vision**

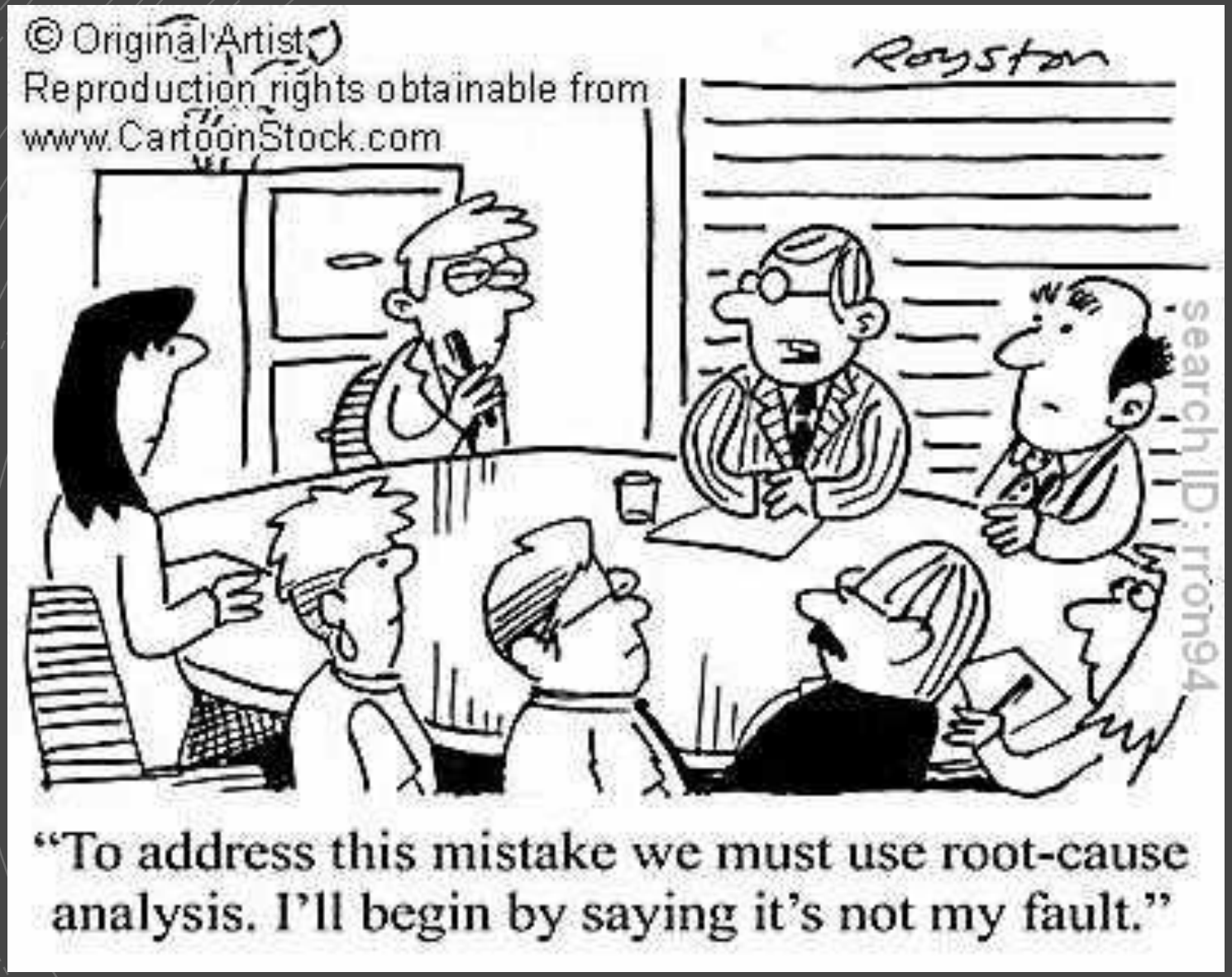
The Blame Game

- Blame/shame:
  Whose fault is this?

- Just find that one person who messed up and we find the cause. NO!

- Moving from *who* did it to → *why* did this happen?

- Ask why again, and again, and again…..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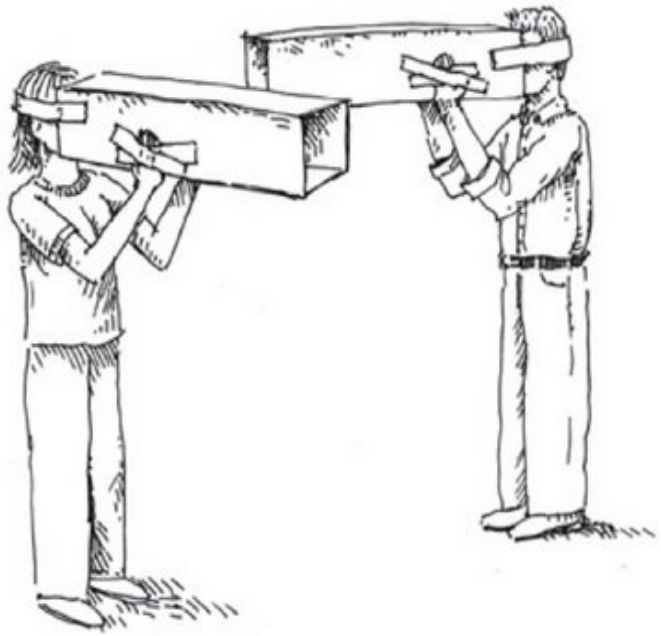
Royston
search ID: rron94
"To address this mistake we must use root-cause analysis. I'll begin by saying it's not my fault."

Tunnel Vision

- At the time the accident occurred, people usually behave seeing only one way to perform. They didn't see all the other things they could have done or the outcomes from what they would do.
- In reconstructing the event, we most often view the event from outside of their tunnel vision. We now have hind-sight knowledge.
- We look at the event seeing all the options the person should have done.



Steps to Root Cause Analysis:

Step One →

Step Two →

Step Three

1. What happened: Gather the clues and evidence by observation, examination, interviews and assessment.

2. Why did this happen? What conditions allowed this problem to exist? Investigate, assess and deduce. Determine the primary root causes or reasons for the fall based upon the aggregate data tracked.

3. Implement corrective actions and interventions to eliminate the root cause(s) of the problem. What can be done to prevent the problem from happening again? How will it be implemented? Who will be responsible to do what? How will it be audited and evaluated?

Post Fall RCA:

Root Cause(s) Analysis:

- Why did they fall? →
- What were they doing before they fell? →
- But, what was different this time? →
- Where did they fall? →
- When did they fall? →
- What was going on when they fell?
- So, why did they fall? →

3 Areas to Investigate for Root Cause Analysis

1. **Internal / Intrinsic conditions**
2. **Environmental / Extrinsic conditions**
3. **Operational / Systemic conditions**

Why might he fall?

What are the clues?

What can you and your staff do to prevent him from falling?

Why might he fall? What are the clues?
What can you and your staff do to
prevent him from falling?

Internal Evidence & Clues:

VITAL SIGNS

NEURO CHECKS

LAB RESULTS

DIAGNOSES

VISION AND HEARING CONDITIONS

COGNITIVE, CONFUSION, MOOD STATUS

RECENT CHANGES IN CONDITIONS

Internal Evidence & Clues:

- **What was the resident doing or trying to do just before they fell?**
  - **Ask them**
  - **All residents, all the time**
- **Place of fall:**
  - **At bedside, 5 feet away, > 15 feet**
  - **Orthostatic, Balance/gait, Strength/endurance**
  - **In bathroom / at commode: / contents of toilet**
  - **Urine or feces in toilet/commode?**
    Urine on floor?

Internal Evidence & Clues:

Medications

- **Side effects, adverse drug reactions, Black Box Warnings**
- **Cascading medications**

Wandering vs. Pacing

- **Wandering:** without a goal, usually provides comfort
- **Pacing:** a need not met, rhythmic or repetitive

Grabbing vs. Pushing

- **Grabbing:** due to dizziness to stop from spinning – don't move, hold on to resident.
- **Pushing:** to get away from being startled/attacked – slowly back away from resident.

Cognitive Abilities & Mood Status

Systemic Evidence & Clues:

- Time of day
- Shift change
- Break times
- Day of week
- Location of fall
- Type of fall (transfer, walking, reaching)
- Staff times, staff assignments, # of staff
- Routines of services

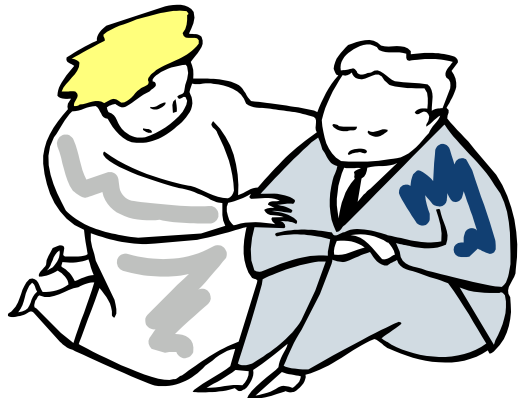
Extrinsic

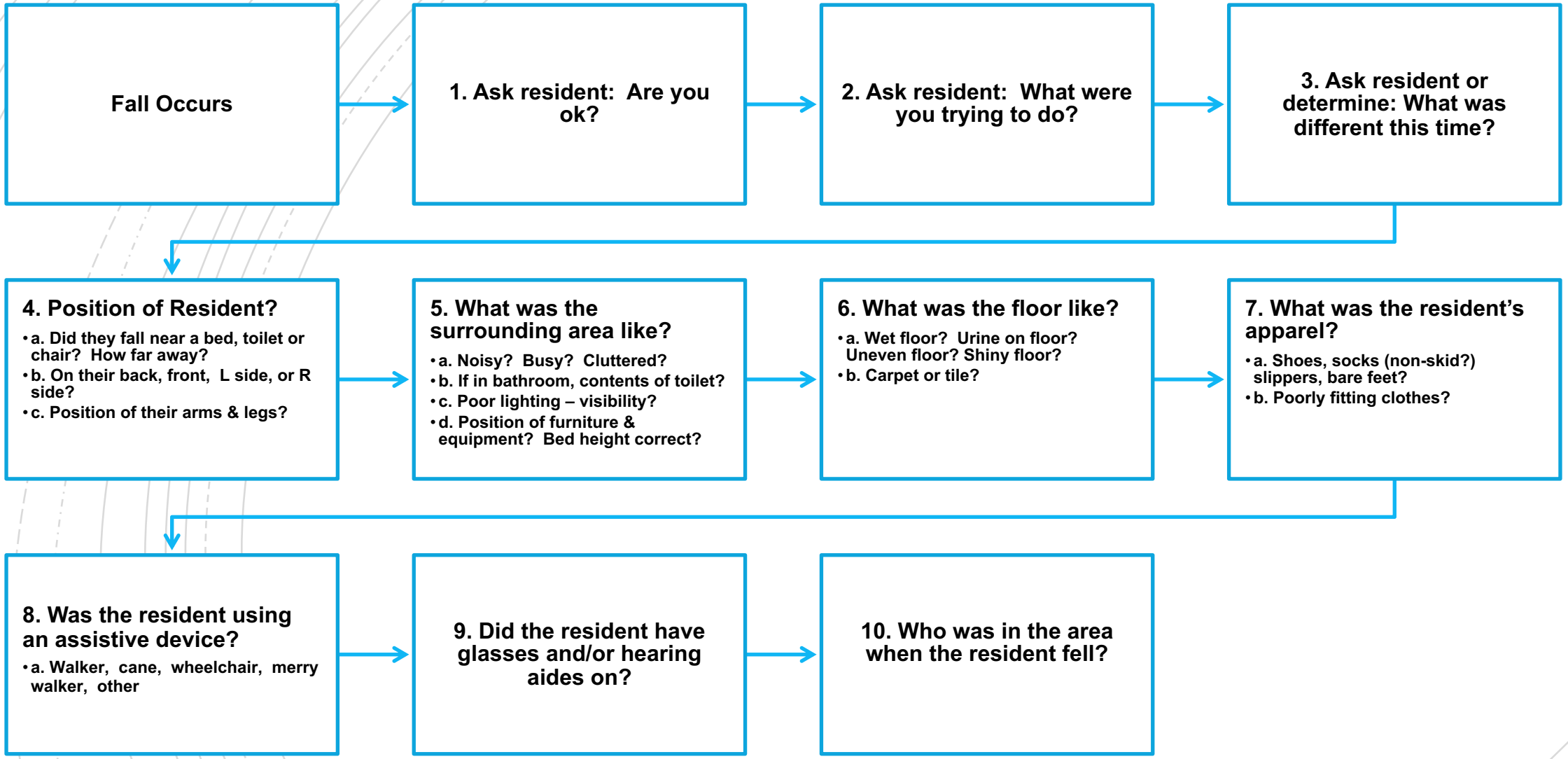
- Noise (alarms, staff, TV)
- Environmental contrasts
- Bed heights
- Room/bed assignment
- Placement of furniture & personal items
- Mats, footwear, lighting, flooring

When you see a resident who has fallen, do the following:

"Check, Call, Care"

1. **Immediately go to the resident, stay with the resident**
2. **If you are not a nurse, call for a nurse**
3. **Encourage the resident not to move, "Are you OK?"**
4. **Ask them, "What were you doing just before you fell?" "What were you trying to do just before you fell?"**
5. **Begin getting answers to the "10 Questions"**
6. **Stay for the fall huddle, assist in getting a fall huddle started**




Fall Occurs
1. Ask resident: Are you ok?
2. Ask resident: What were you trying to do?
3. Ask resident or determine: What was different this time?
4. Position of Resident?
• a. Did they fall near a bed, toilet or chair? How far away?
• b. On their back, front, L side, or R side?
• c. Position of their arms & legs?
5. What was the surrounding area like?
• a. Noisy? Busy? Cluttered?
• b. If in bathroom, contents of toilet?
• c. Poor lighting – visibility?
• d. Position of furniture & equipment? Bed height correct?
6. What was the floor like?
• a. Wet floor? Urine on floor? Uneven floor? Shiny floor?
• b. Carpet or tile?
7. What was the resident's apparel?
• a. Shoes, socks (non-skid?) slippers, bare feet?
• b. Poorly fitting clothes?
8. Was the resident using an assistive device?
• a. Walker, cane, wheelchair, merry walker, other
9. Did the resident have glasses and/or hearing aides on?
10. Who was in the area when the resident fell?

Fall Huddle

- Performed immediately after resident is stabilized
- Charge nurse has all staff, working in the area of the fall, meet together to determine RCA
- Review “10 Questions” with staff
- Also ask staff:
  - “Who has seen or has had contact with this resident within the last few hours?”
  - “What was the resident doing?”
  - “How did they appear?
  - How did they behave?”

Hourly Rounding or the “4 Ps”

- *Position:*
  - Does the resident look comfortable?
  - Ask the resident, “Would you like to move or be repositioned?”
  - Ask the resident, “Are you where you want to be?” Report to the nurse.
- *Personal (Potty) Needs:*
  - Ask the resident, “Do you need to use the bathroom?”
  - Ask if they’d like help to the toilet or commode. Report to the nurse.
- *Pain:*
  - Does the resident appear in to be uncomfortable or in pain?
  - Ask the resident, “Are uncomfortable, ache or in pain?”
  - Ask them what you can do to make them comfortable.
  - Report to the nurse.
- *Placement:*
  - Is the bed at the correct height?
  - Is the phone, call light, remote, walker, trash can, water, urinal, tissues, all near the resident?
  - Place them all within easy reach.

Summary

- Use Root Cause Analysis to identify Why the fall occurred
- Implement interventions that are appropriate for what occurred
- Identify intrinsic, extrinsic, and systemic actions that can cause a fall to occur.

Resources

- **Fall Prevention and Elimination; Evidence Based Resources, Reports of Practice, Articles: Empira, 2013**
- **Sound, Noise and Alarm Reduction:**
- **"Nursing Home Alarm Elimination Program: It's Possible to Reduce Falls by Eliminating Resident Alarms."** MASSPRO, Quality Improvement Organization for Massachusetts, Nursing Home Initiative: 2006**.** Website publication: http://www.masspro.org/education.php
- **"Strategic Approaches to Improving the Care Delivery Process, Falls and Fall Risk."** Dr. Steven Levenson, MN Joint Coalition Statewide Training. May 2010**.**

Questions?

Van Safety

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Free of Accidents Hazards/Supervision/Devices

The facility must ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Systems Approach

1. Identify hazard and risks
2. Evaluate and analyze the risks
3. Implement / educate interventions to reduce risk
4. Monitor interventions and modify if needed

Transportation Program

Transportation Safety

- Improperly functioning shoulder strap
  - What if this happens while you are out?
- Staff training
  - All aspects of van use
  - How/Who to report repairs needed
  - Lift Use
    - Positioning
  - Wheelchair restraint usage
    - Avoid tipping backward
  - Manufacturer's Guidelines
- Adequate supervisions
  - When transporting 2 or more residents
  - Resident who is care planned as 2 person transport
- Routine inspection
  - General
  - Restraint system – shoulder & wheelchair
  - Lift system

Transport Van

- Transport Van's wheelchair restraints were securely & properly applied per manufacturer's instructions
- Van/wheelchair restraint manufacturer's instructions were readily available
- Transport Van restraints were routinely inspected by a qualified professional (Dealer) to ensure they are in proper working order per manufacturer's guidelines
- Transport staff members were trained on manufacturer's instructions (Manufacturer's DVD demo)
- Transport staff members returned demonstrated manufacturer's instruction during orientation & periodically

Van Safety

- Goal:
  - Transport residents from the pick-up point to the drop-off point in the safest and most efficient manner possible.

Van Safety

- Extra Precautions
  - Regardless of which anchorage system you are using, it is always a good habit to shake the fitting to ensure it is completely locked into the anchorage.
  - Anchorages should be as free of dirt and debris as possible to reduce the false feeling of the fitting being totally engaged into the anchorage when in fact it may be only wedged with dirt.
  - Always remove the retractors from the floor and place them into the wall pouch when not in use, to prevent tripping hazards.

Inventory and Inspection

- It is extremely important that you conduct a thorough pre-trip inspection of your vehicle.
- The securement system is an essential part of the inspection.
- It is very embarrassing to arrive at your first stop and find that you do not have the necessary tie-downs to secure a wheelchair or that the equipment is inoperable.

Inventory

- For each wheelchair station you should have the following:
  - Four retractors with proper floor anchorage fittings
  - One lap belt assembly
  - One shoulder belt assembly, may be in combination with the lap belt
  - Possibly two webbing loops
  - One belt cutter

Inspection

- The inspection should consist of at least the following items:
  - Check the retractors by pulling out the webbing to ensure they are locking properly.
  - Check to ensure webbing is not cut, frayed, damaged or contaminated by polishes, oils or chemicals.
  - Check that metal parts are not worn, broken or cracked.
  - Check pin connector bushings to ensure they are not cracked, broken or missing.
  - Check that all mounting hardware such as bolts, nuts, etc. are secure.

Inspection

- The inspection should consist of at least the following items:
  - Check floor anchorages to ensure it is not cut, frayed, damaged or contaminated by polishes, oils or chemicals.
  - Check buckles for damage and ensure proper operation.
  - Check male buckle pin connector bushing to ensure it is not cracked, broken or missing.
  - Check any other parts of the securement system and accessories that may not be specifically indicated in this checklist but are pertinent to a safe and operational system.

Inspection

- Any parts that are in question should be reported and replaced or repaired prior to departure.
- After you have completed your inventory. And inspection, return the tie-downs to their individual wall pouches or other suitable container.

Preventative Maintenance Checklist

- ❑Inspect the retractors by pulling out the webbing to the maximum and allow it to rewind onto the spool
- ❑Inspect the retractors to ensure they are locking properly
- ❑Inspect to ensure webbing is not cut, frayed, damaged or contaminated with polishes, oils or chemicals
- ❑Inspect all metal parts to ensure they are not worn, cracked or broken
- ❑Inspect pin connector bushings to ensure they are not cracked, broken or missing
- ❑Inspect that all mounting hardware, such as bolts, nuts, etc. are secure
- ❑Inspect floor anchorages to ensure cleanliness and proper securement

Preventative Maintenance Checklist

- ❑ Inspect aluminum track and hardware for any signs of corrosion
- ❑ Inspect track and/or anchorage fittings for proper operation
- ❑ Periodically it may be necessary to wash the fittings in a parts washing solution and lubricate with WD-40 or similar lubricant to ensure proper operation of the positive locking features
- ❑ Inspect shoulder belt anchorages for proper securement and operation
- ❑ Inspect lap and shoulder belt webbing to ensure it is not cut, frayed, damaged or contaminated with polishes, oils or chemicals
- ❑ Inspect buckles for damage and ensure proper operation

Preventative Maintenance Checklist

- ❑ Inspect male buckle pin connector bushing to ensure it is not cracked, broken or missing
- ❑ Retractable lap and/or shoulder belts should have webbing pulled out to the maximum and allowed to rewind onto the spool
- ❑ Lap and/or shoulder belt retractors are Emergency Locking Retractors (ELR) and should be checked by giving a quick jerk on the webbing to ensure the retractor is locking properly
- ❑ Clean webbing periodically, as needed, with mild soap and water. After cleaning, fully extend the belts and position them to prevent water from entering the retractors until completely dry
- ❑ Inspect any other parts of the securement system and accessories that may not be specifically indicated in this checklist, but are pertinent to a safe operational system

Preventative Maintenance Checklist

- All deficiencies should be reported to your supervisor and items either repaired or replaced prior to the vehicle being returned to service.
- Wheelchair tie-downs and occupant restraint systems (WTORS) including anchorages that are suspected to have been in use during an impact, from which the vehicle must be towed, should be replaced.

Culture of Safety

- Strong leadership
- Clearly defined safety policies
- All staff to identify and report safety problems
- Enforcement of safety policies by supervisors and managers
- Regular measurement of staff safety performance
- Analysis and review of procedures
- Safety data and trends provided to all staff

Questions?